Wisconsin Department of Public Instruction
OCULAR REPORT FOR CHILDREN WITH A KNOWN OR SUSPECTED VISUAL IMPAIRMENT
PI-2015 (Rev. 05-01)

INSTRUCTIONS: To be completed by a vision care specialist (ophthalmologist or optometrist). Send a completed copy to the referring individual or to the child's school district.

CONFIDENTIAL *TYPE OR PRINT* **COMPLETE BOTH PAGES**

I. GENERAL INFORMATION

Student's Name	Sex	Date of Birth

Name of Parent	Address of Parent *Street, City, County, State, Zip*	Telephone *Area/No.*

Signature of Parent* ➢	Date Signed

**Consent: Parent signature for Voluntary Release to county agency (if the child is B-3), local school district, Department of Public Instruction for purposes of educational programming and/or registry with the American Printing House for the Blind. This consent can be revoked at any time, cannot be redisclosed to others for any purpose, and is valid for three years from date signed.*

II. REFERRAL

Name of Person Making Referral	Address *Street, City, State, Zip*	Telephone *Area/No.*

QUESTIONS AND CONCERNS BY REFERRING PERSON

PHYSICIAN RESPONSE

Were Low Vision aids recommended? ❑ Yes *If Yes, please list.* ❑ No

III. SIGNATURES

Name of Examiner *Please Print*	Date of Examination	Recommended Date for Next Exam

Signature of Examiner ➢	❑ M.D. ❑ O.D.	Date Signed

Address *Street, City, State, Zip*	Telephone *Area/No.*

IV. MEASUREMENTS

Measurements are: ❑ Accurate ❑ Approximate

Visual Acuity	Distant Vision: Without Correction	Distant Vision: With Best Correction	Near Vision *in M Sizes*: Without Correction	Near Vision *in M Sizes*: With Best Correction	Prescription: Sph.	Prescription: Cyl.	Prescription: Axis	Prescription: Add
Right Eye (O.D.)								
Left Eye (O.S.)								
Both Eyes (O.U.)								

Instruments Used

❑ Preferential looking tests
❑ VEP Visual Evoked Response
❑ Lighthouse
❑ Feinbloom
❑ Snellen
❑ Lea Symbols
❑ HOTV
❑ Other _____

Is child determined to be legally blind (**equivalent to 20/200 Snellen Acuity**) for distance vision? ❑ Yes ❑ No

Field Loss
Tested ❑ Yes ❑ No
If Yes ❑ Central ❑ Peripheral

Widest Diameter of Remaining Visual Field
In degrees
❑ O.D. _____ ❑ O.S. _____

Is Child Legally Blind from Field Restriction:
20° or less
❑ Yes ❑ No

Does the child exhibit deficits in:
❑ Color Vision ❑ Depth Perception ❑ Night Vision

If unable to test, does the diagnosis suggest a visual acuity of 20/70 or less in the better eye after correction or a field restriction of 50° or less?
❑ Yes ❑ No

V. CAUSE OF BLINDNESS OR VISUAL IMPAIRMENT

Present ocular and/or cortical condition(s) responsible for vision impairment and Etiology.

Etiology:

Present Ocular Pathology: ❑ O.D. ❑ O.S. ❑ O.U.

Cortical Visual Impairment: ❑ Yes ❑ No

VI. PROGNOSIS AND RECOMMENDATIONS

A. Student's Vision Impairment ❑ Stable ❑ Degenerative ❑ Uncertain ❑ Potentially Degenerative

B. Recommended Treatment: ❑ Patching ❑ Drops ❑ Pressure Checks ❑ Low Vision Evaluation
❑ Other *Specify* _____

C. Glasses or Contacts *Check all that apply:*
❑ Prescription ❑ Tinted Lenses/Sunglasses ❑ Safety Lenses ❑ Not Needed
❑ Worn constantly ❑ Worn for distance viewing ❑ Worn for close work

D. Physical Activities *Is there a medical reason for limiting participation in contact sports or physical education?* ❑ No
❑ Yes *If yes, explain.*